Central West **LHIN**
RLISS du Centre-Ouest

Annual Business Plan 2014/15

Central West Local Health Integration Network

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Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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A Message from the Board Chair and CEO

The Central West Local Health Integration Network (LHIN) is pleased to present its 2014/15 Annual Business Plan (ABP 2014/15) for the fiscal year beginning April 1, 2014 and ending March 31, 2015.

Each year the LHIN develops a formal business plan that describes how it will allocate resources to implement the strategic directions identified in its three-year strategic plan, commonly referred to as the *Integrated Health Services Plan* (IHSP). ABP 2014/15 represents an allocation of resources for the second year of the Central West LHIN's current IHSP 3.

ABP 2014/15 outlines specific activities the LHIN will undertake to implement the four strategic directions, including their corresponding strategic initiatives, identified in IHSP 3. These four strategic directions include: Improve Access to Care, Streamline Transitions and Navigation of the System, Drive Quality and Value and Build on the Momentum. Throughout ABP 2014/15 specific attention is given to the current status of each initiative, activities to be completed during the coming fiscal year, the impact these initiatives/activities will have on the local health system and performance measures that will be used to gauge LHIN success. In addition, ABP 2014/15 includes an overview of plans related to operations (finance and staffing) and communications/community engagement.

While the Central West LHIN's strategic directions are shaped by provincial priorities, ABP 2014/15 reflects local initiatives. It describes how the LHIN, in collaboration with Health Service Providers (HSPs) and community partners, is implementing *Ontario's Action Plan for Health Care* with the aim of providing Better Health, Better Care and Better Value to local residents.

Both residents and health care professionals alike place high value on the health care system and the need for it to be responsive to local communities. The Central West LHIN would like to thank the many HSPs, community partners and local residents who have taken ownership and responsibility for evoking meaningful change. Their dedication, commitment and collaborative efforts toward the provision of high-quality, person-centred, local health care are transforming a bold vision into reality.

The Central West LHIN's work is focused on the development of an integrated system of health services aimed at improving access to the right care, at the right time and in the right place. As we implement ABP 2014/15 we move closer to achieving this objective.

Maria Britto
Board Chair, Central West LHIN

Scott McLeod
Chief Executive Officer, Central West LHIN

OVERVIEW | ABP 2014/15

ABP 2014/15 is the Central West LHIN's work plan for fiscal year beginning April 1, 2014 and ending March 31, 2015. It outlines key activities the LHIN will undertake to implement the strategic directions and initiatives outlined in the second year of its current Integrated Health Services Plan - IHSP 3. As an extension of IHSP 3, ABP 2104/15 indicates how, in collaboration with local Health Service Providers (HSPs) and the broader health care sector, the LHIN will work to improve the health of local residents.

IHSP 3 is focused on four strategic directions that aim to improve access to local health care services and to better integrate those services across the continuum of care. It aligns with *Ontario's Action Plan for Health Care*, the Ministry of Health and Long Term Care (MOHLTC) strategy that is focused on building a health system more responsive to residents, while delivering better value for money. it also aligns with pan-LHIN system imperatives, which focus the collective efforts of all 14 LHINs on navigating and facilitating the transition of residents across the health care system and between health care providers.

ABP 2014/15 is divided into four main sections:

- **Section 1 | Context**... provides an overview of the Central West LHIN's mandate, strategic directions and alignment with MOHLTC and pan-LHIN priorities; population and health profiles of local residents; a summary of current activities; and, an assessment of potential challenges to the local health care system.

- **Section 2 | Healthy Change in Action**... outlines specific work the Central West LHIN will undertake in 2014/15 to support the strategic directions of IHSP 3; describes the performance measures and targets that will be used to assess progress; and, reviews potential risks/barriers to successful implementation.

- **Section 3 | Financial Plan, Staffing and Operations**... provides a three-year spending plan for Central West LHIN Operations, in addition to a summary of current and proposed staffing levels.

- **Section 4 | Communications and Community Engagement**... describes the Central West LHIN's goals, objectives and evaluation measures as they relate to communications & community engagement during the coming fiscal year.

The success of ABP 2014/15 will be documented in the Central West LHIN's Annual Report which looks back on work accomplished, chronicling how LHIN activities are enabling delivery of the right care, in the right place at the right time for local residents.

In partnership with the MOHLTC, HSPs, community partners and residents the Central West LHIN is working to ensure a sustainable local health system that delivers high-quality, person-centered, health care for current and future generations.

SECTION 1 | Context

1.1 LHIN Mandate, Strategic Directions and Alignment

Under the Local Health System Integration Act (*LHISA*, 2006) the Central West LHIN was established and given the authority to plan, integrate, fund and monitor the local health care system for the purpose of improving the health of residents who live in communities within the LHIN's geographic boundaries. Given its mandate, the LHIN has established a set of principles to guide its planning process:

Central West LHIN - Guiding Principles

- Equitable access based on patient/client need
- Preservation of patient/client choice
- People-centered, community-focused care that responds to local population health needs
- Measureable, results-driven outcomes based on strategic policy formulation, business planning and information management
- Shared accountability between providers, government, community and citizens.

The following strategic directions and accompanying initiatives, outlined in IHSP 3, will guide this year's activities:

Improve Access to Care

- Primary Health / Family Health Care
- Chronic disease prevention & management programs
- Mental Health and addictions services
- Community-based services for seniors

Streamline Transitions & Navigation

- Improve linkages with and among Primary Health / Family Health Care and other providers in the health system
- Improve system navigation resources
- Increase system collaboration through use of information technologies

Drive Quality & Value

- Ensure an overarching LHIN quality framework
- Optimize use of health care resources to foster better care

Build on the Momentum

- Aboriginal Health
- Diversity and Health Equity
- French language Services
- Palliative Care
- Women and Children's Health

The LHIN's strategic directions are aligned with *Ontario's Action Plan for Health Care* and pan-LHIN system imperatives, and the Central West LHIN vision is one shared by all 14 LHINs, regardless of where residents reside in the province:

"To create a health care system that helps people stay healthy, delivers good care when people need it, and that will be there for our children and grandchildren".

Ontario's Action Plan for Health Care	Central West LHIN's IHSP 3: 2013-2016	Pan-LHIN System Imperatives
Keeping Ontario Healthy	Drive Quality and Value	Leading with quality and safety
Faster access to stronger primary health care	**Improve Access to Care**	Strengthening and enhancing access to primary care
Right Care, Right Time, Right Place	Streamline Transitions & Navigation	Enhancing coordination and transitions of care for targeted populations
	Build on the Momentum	Holding the gains

1.2 The Landscape: Environmental Scan of LHIN Residents

Population Profile

The Central West LHIN is home to over 840,000 residents who make up seven percent of Ontario's total population. The population is predominantly urban; 86% percent of residents reside in urban areas, while the remaining 14% percent live in a mixture of urban/rural (8%) and rural communities (6%). The Central West LHIN also has one of the highest population growth rates in the province. Between 2006 and 2011 the number of residents increased by 11% percent, as compared to six percent across the province. This growth is projected to continue, climbing by an additional 23% percent over the next seven years to 1,030,500 residents by 2021.

Among the 14 Ontario LHINs, the Central West LHIN currently has the lowest proportion of senior residents. Those aged 65 and over comprise 11% percent of the LHIN's total population, as compared to 14% percent in Ontario. While seniors appear to be healthy with high life expectancy, low crude mortality and a lower prevalence of all major chronic diseases, estimates project that the Central West LHIN will experience unprecedented growth in the seniors population, rising 64% percent by 2021 as compared to 43% percent growth predicted for Ontario. The fastest growing group are those aged 65 to 74, with a projected increase of 64% percent by 2021.

The Central West LHIN is also one of the most diverse communities in the province. Over half of local residents belong to visible minority groups, as compared to the provincial average of 26% percent. Almost half of the population are immigrants (47%) and 13% percent of residents are newcomers to Canada within five years. 58% percent of local LHIN residents report English as their mother language and four percent report no knowledge of either official language - the second highest rate in the province. The LHIN is home to over 16,000 Francophones and 5,600 residents who self-report as indigenous people.

Health Profile

Six percent of adults residing within the Central West LHIN have one chronic condition; 14% percent have multiple chronic conditions. 36% percent of local residents are obese and 60% percent are physically inactive. At 12% of the total population, the LHIN also has the third highest prevalence rate of diabetes in Ontario. Since 2010, the prevalence of diabetes has risen by 20% percent. Both incidence and prevalence rates are substantially higher than provincial averages. Among the diabetic population, the demand for acute services, specialty care and clinical interventions is increasing.

Over the past several years, the Central West LHIN has also experienced an increase in the number of Emergency Department (ED) visits, acute hospitalizations and re-visits for mental health and addictions issues, particularly among youth aged 12-24 years. The rate of visits to a Health Service Provider (HSP) for mental health and addictions is significantly higher than the provincial average (22% vs 14%), and median wait times for community support services, case management, counselling/treatment, early intervention programs and supportive housing continue to exceed those in neighboring LHINs.

Seniors make up approximately half of the Central West LHIN's active, complex, high-use population; those who require repeated admissions to hospital and/or long length of stays in acute, post-acute and community-based care. These residents access the system frequently and at multiple entry points, often defaulting to the ED, which can result in uncoordinated care.

Meanwhile, rates among specific disease groups are improving. Chronic Obstructive Pulmonary Disease (COPD), heart disease and stroke are among the lowest in the province. Mortality rates for arthritis, cancer, COPD, hypertension and Ischemic Heart Disease are also among the lowest in Ontario. With the exception of arthritis, all chronic conditions are decreasing and the percentage of residents over 75 years of age with heart disease is lower than the Ontario average.

1.3 Current Programs and Activities in the Central West LHIN

Health Service Providers

Through a base budget of $845 million, provided by the MOHLTC, the Central West LHIN funds HSPs and community partners in the regions of Brampton, Caledon, Dufferin, Malton, north Etobicoke and west Woodbridge. Specifically;

- Two hospital corporations, operating three hospital sites attending over 70,000 hospital admissions and 233,500 unscheduled ED visits/year
- One Community Care Access Centre (CCAC) serving 32,500 clients/year
- 23 Long-Term Care (LTC) homes providing an estimated 750,000 resident days/year
- Two Community Health Centers (CHC), operating 5 locations delivering over 25,000 primary care visits/year
- 14 agencies offering community support services (CSS) to an estimated 40,000 clients/year
- Eight organizations that provide mental health, addictions and problem gambling services.

Service Accountability Agreements (SAAs)	Funded	Base Budget	% of LHIN Funding
Acute Care Hospitals	2	$519,368,480	62.1%
Community Care Access Centres (CCACs)	1	$102,881,178	12.3%
Community Health Centres (CHCs)	2	$12,077,359	1.4%
Community Support Services (CSS)	14	$19,065,100	2.3%
Long-Term Care Homes (LTC)	23	$150,102,674	18.0%
Mental Health and Addictions Services	8	$32,512,391	3.9%

Service Localization

More residents leave the boundaries of the Central West LHIN to receive hospital care, rehabilitation and long-term care in comparison to the number of non-residents who come into the LHIN for service. Residents leave the LHIN seeking specialty mental health and addictions services, stroke care, cancer care, cardiac care, orthopedic procedures, complex pediatrics and specialty rehabilitation. The majority of outflow is to receive specialized care from providers in the Toronto Central and Mississauga Halton LHINs.

Health System Funding Reform (HSFR)

Consisting of two financial components - the Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBPs) - the Health System Funding Reform (HSFR) approach was introduced effective April 1, 2012.

HBAM is an allocation model and management tool that uses demographic, clinical and financial information to estimate expected volumes of patients and costs at a facility level. This is then used to identify an organization's expected share of overall sector funding. QBP's are targeted activities funded on a "price per volume" basis. They are funded based on evidence (e.g. utilization patterns, best practices) to encourage improvement in value for money, including improved outcomes and reduced variation across providers.

Despite the Central West LHIN's aging population and an increased demand for many funded services, service volumes and funding for the Central West LHIN, through HSFR, have remained steady since fiscal 2012/13.

1.4 Areas of Opportunity | Challenges on the Road Ahead

Building on the Momentum

In September 2013, the LHIN conducted a public poll involving a random sampling of 600 residents across the LHIN's boundaries. Results revealed that local residents are satisfied with the quality of health care services they have received. A majority of residents are increasingly satisfied with access to local health care services including physicians. In addition, a majority of local residents are satisfied with the system's capacity to accommodate diversity and its ability to provide fair and equitable services for all. Overall, residents feel their health care has changed for the better.

Increasing Complexity of Patients Requiring Home Care Services

The volume and acuity/complexity of clients discharged from hospital to the community is rising. As a result, the Central West Community Care Access Centre (CCAC) is facing higher demand for increased complex care requirements. In order to meet and address the increasing demand for higher acuity home care services, the Central West CCAC wait-lists clients with lower overall acuity. These individuals are vulnerable to further health declines, ambulatory revisits and hospitalization.

Long-Term Care (LTC) Home Capacity

The number of new referrals made to LTC homes each month continues to exceed the number of beds placed, and the 90th percentile wait time for basic accommodation approaches or exceeded two years in 78% percent of Central West LHIN funded homes. LTC homes are challenged to accommodate hard-to-place clients with behavioural barriers, which is a contributing factor to alternative level of care (ALC) days in LHIN hospitals.

Demand for Community Support Services is Outstripping Supply

Several Community Support Service (CSS) agencies that offer assisted living, adult day programs and social/congregate dining are reporting wait times of over one year, from the time of referral to service initiation. Without more services and funding to support aging at home, the burden of care can fall on the shoulders of family members and neighbours to assist residents to live independently.

Demand for Surgical Procedures Exceeds Funded Volumes

Wait times for orthopedic hip/knee replacement and cataract repair continue to climb above best practice guidelines, and are among the highest in the province. Local hospitals are performing these procedures only to funded quality-based procedure (QBP) volumes, despite an ever-growing demand for the procedures. This is resulting in growing wait lists and an outflow of residents seeking shorter wait times in neighbouring LHINs.

Health System Funding Reform (HSFR) Funding Does Match Growing Demand for Services

Due to the Central West LHIN's population growth and its aging population demographics, service and funding pressures continue to grow as the gaps between service demand for hospitals and home care agencies funded through HSFR exceed allocations.

Wait Times for Community Mental Health Services are Rising

Facing long wait times for community mental health/addiction services, clients increasingly present to ambulatory centres in crisis. Local EDs are reporting a rise in the number of youth presenting with substance abuse/addictions issues and arriving on involuntary forms.

Cultural diversity of residents

The unique challenges local HSPs face in communicating with residents in the LHIN needs to be addressed. Greater understanding of ethno-cultural influences on health and medical intervention is vital to meeting the health and social needs of our diverse population.

SECTION 2 | Healthy Change in Action

Improve Access to Care

2.1 Improve Access to Primary Health / Family Health Care

IHSP Initiative Description

The Central West LHIN continues to work with Family Health Teams (FHTs), Community Health Centres (CHCs) and primary care practitioners to ensure residents have timely access to multi-disciplinary primary care, and to provide care in appropriate primary care settings with the aim of reducing avoidable hospital use; specifically, unnecessary visits to Emergency Departments (EDs) and admissions.

Current Status

Close to 600 family physicians practice within the Central West LHIN (OPHDRC, 2012). Residents are served by six FHTs, two CHCs, 33 Family Health Groups (FHGs), 13 Family Health Organizations (FHOs) and over 180 individual fee-for-service practitioners.

Attachment to a primary care physician is high; 95% percent of LHIN residents reported they had a regular family doctor in 2012/13 (Health Care Experience Survey, September 2013). While most residents report having access to a family doctor, access to their provider when service is needed remains a concern - 49% percent of residents reported being able to see their primary care provider on the same or next day when needed. Residents do not appear to be turning to local EDs for conditions that should be manageable within the community. Central West LHIN EDs have lower proportions of low acuity visits compared to the provincial average (Canadian Triage and Acuity Scale IV/V: 28% vs 40%). They also have the lowest rate of ED visits among the 14 LHINs for conditions that could be treated in primary care settings such as conjunctivitis, cystitis, otitis media and upper respiratory infections (1.7 per 1,000 population aged 1-74 years). However, there is evidence to suggest these conditions are not being treated by primary care providers. The high number of walk-in clinics in the Central West LHIN suggests residents are seeking lower acuity care in venues that do not provide the continuity of care inherent in a primary care practice.

In 2013/14, the Central West LHIN played a key role in the collaborative design and implementation of Health Links, being one of the first of Ontario's 14 LHINs to fully implement Health Links across the entire geographic area. Five local Health Links were created, each having adopted a common business plan and standard model of care to ensure a consistent experience for patients and providers. Health Links in the Central West LHIN include Bramalea and Area, Brampton and Area, Dufferin Area, North Etobicoke - Malton - West Woodbridge Area, and Bolton - Caledon Area.

Collaborative efforts resulted in the adoption of a common definition of "high-use" residents across the Central West LHIN, which has formed the basis for ongoing identification of candidates for the Health Links program. Health Links increases the effectiveness of primary care providers for high use residents and encourages greater collaboration among local service providers.

The Central West LHIN also established a Primary Care Network. Led by the Physician Primary Care Lead, this group is focused on developing diverse engagement strategies and partnerships for local primary care practitioners.

Alignment with Government Priorities

Ontario's Action Plan for Health Care identifies faster access to primary care and improved transitions between providers as key components to ensuring Ontarians receive the right care, at the right time and in the right place. Through the collaborative work of Health Links, FHTs, CHCs, the Central West CCAC and the Primary Care Network, these actions will ensure patients receive faster care, spend less time waiting for service and are supported by a team of providers across the local health care system.

Action Plans/Interventions	2014/15	2015/16	2016/17
Work with Health Links and Health Care Connect to ensure residents, who do not have a primary care practitioner, are assigned one.	In Progress 70%	30%	Ongoing
Work with FHTs CHCs, Health Links and the Primary Care Network to improve access to multi-disciplinary primary care, advanced access models, and specialty care as close to home as possible.	In Progress 60%	40%	Ongoing
Continue to identify "high use" patients within the LHIN on an ongoing basis and ensure that each high user has a documented care coordination plan.	In Progress 60%	40%	Ongoing

Expected Impacts of Key Action Items

By the end of 2014/2015, all high users within the LHIN will have active coordinated care plans. More residents will have access to after-hours care and same-day or next-day appointments and fewer individuals will require care in ambulatory centers for conditions manageable in primary care settings.

Outcome Metrics:

- Increase the proportion of residents who report access to same or next-day appointments to 60%.
- All residents enrolled in Health Links will have a coordinated care plan.
- Maintain current performance on avoidable emergency department visits for conjunctivitis, cystitis, otitis media and upper respiratory infections (< 1.5 visits per 1,000 population aged 1-74 years).

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Year over year population growth will increase pressure on the availability of, and access to, local family physicians for residents within the LHIN.	▪ Continue to utilize and monitor referral patterns to primary care through Health Care Connect. ▪ Monitor physician supply, recruitment and model adoption through the LHINs Health Force Ontario Community Partnership Coordinator. ▪ Monitor referral patterns to Health Links for barriers to access and growth in demand.
Access to and communication of relevant patient information across Health Service Providers impedes timely access to care.	▪ Continue to adopt and support the use of eHealth infrastructures that improve the availability and transferability of client-based information.
Lack of physician support for LHIN initiatives.	▪ The LHIN will implement a managed growth model of physician engagement/relationship development. ▪ The LHIN will continue to work with OMA/OCFP physician leaders, the Primary Care Lead and the Primary Care Network to support buy-in to projects and initiatives.

Key Enablers

Building on strong partnerships with local FHTs, CHCs, the five Health Links and the Central West CCAC, the LHIN will continue to support and invest in efforts that forge relationships, information exchange and patient transitions between primary care, acute care and community service partners.

2.2 Improve Access to Chronic Disease Prevention and Management Programs

IHSP Initiative Description

The LHIN is working with community partners to increase capacity for the self-management of chronic conditions in order to improve the treatment and management of chronic diseases in the community. Improvements made, with respect to the coordination of regional diabetes services, will continue. In the second year of IHSP 3, the LHIN will expand education and self-management programs for chronic diseases, to include Congestive Heart Failure (CHF).

Current Status

In 2013/14, the Diabetes Regional Coordination Centre (DRCC) and its associated educational resources became fully integrated within Central West LHIN operations. Four Health Service Providers (HSPs) now deliver Diabetes Education Programs funded by the Ministry of Health and Long-Term Care (MOHLTC), the active caseload for which has increased by three percent for residents attending local Diabetes Education Programs.

The rate of ED visits for hyperglycemia and hypoglycemia remained at 220 visits per 100,000 population and the number of readmissions to hospital within 30 days of discharge, for conditions related to diabetes, was at or below the evidence-based expected rate in all four quarters. These indicators reflect the collective success of the Central West LHIN's Diabetes Education Programs and self-management programs. However, the programs report more capacity for additional patients with these services.

This past year, through the newly established regional Telehomecare program, eligible residents with CHF and Chronic Obstructive Pulmonary Disease (COPD) were able to better self-manage their care with the support of technology placed in their home. The successful results of this "pilot" program demonstrate the ability of patients to better manage their own conditions within their communities, thereby avoiding and preventing unnecessary utilization of acute care/ambulatory services.

In 2014/15, the LHIN will begin to explore access to chronic disease education and self-management programs for residents living with CHF. Heart failure is predominantly a chronic disease within the elderly and the most common cause of hospitalization for individuals over 60 years of age. CHF carries a substantial burden of mortality and morbidity for residents in the Central West LHIN. The annual mortality rate of CHF within the LHIN is six percent and morbidity associated with heart failure is high. Each fiscal quarter, 25%-28% percent of residents hospitalized with CHF are re-admitted within 30-days of discharge.

Alignment with Government Priorities

The LHIN is committed to improving access to CDPM programs and services by building on the foundations of the Ontario CDPM Framework, leveraging the work of local diabetes programs and, by expanding roles that promote self-management while delaying and/or preventing the onset of additional chronic diseases. This work is fully aligned with *Ontario's Action Plan for Health Care* in that it places patients at the centre of the health care system, supporting them to self-manage their chronic conditions within the community. By improving access to community support services, we add value to the health system, providing optimal care at a lower cost, outside the hospital setting.

Action Plans/Interventions	2014/15	2015/16	2016/17
Diabetes Education Programs will implement and report on the development of performance improvement plans and progress towards meeting annual program/service targets (ongoing reviews with MOHLTC)	In Progress 10%	60%	30%
Develop and implement three integrated care pathways for the management of diabetes in the Central West LHIN.	In Progress 20%	20%	Ongoing
Evaluate barriers to accessing care for diabetes using the Health Equity Impact Assessment tool.	In Progress 70%	20%	Ongoing
Build on the Chronic Disease Prevention and Management model implemented for diabetes and to adapt to congestive heart failure to assess the application for local residents living with CHF.	Not Yet Started 40%	40%	20%
Identify the scope of services and programs available for CHF in the LHIN as a first step in planning towards integrated and accessible services.	Not Yet Started 100%		
Support awareness of and referrals to the Telehomecare program amongst local health service providers.	In Progress 100%		

Expected Impacts of Key Action Items

By the end of 2015/2016, more residents living in the Central West LHIN will receive diabetes care according to evidence-based best practices and within recommended timelines. Residents living with other chronic diseases including congestive heart failure and chronic obstructive pulmonary disease will receive enhanced support to manage their conditions outside of hospital settings. As a result, fewer individuals will require readmission to hospital following initial disease stabilization.

Outcome Metrics:

- Improve the rate of readmissions within 30-days of discharge for CHF diagnoses to within 10% of the expected rate.
- Maintain a rate of readmissions within 30-days of discharge for diabetes diagnoses within 10% of the expected rate.
- Reduce the rate of emergency room visits for both hyperglycemia and hypoglycemia by 10% by the end of 2015/2016.
- Increase the volume of active adult clients in funded diabetes programs by 5% by 2014/2015 from current levels.
- Increase the proportion of client referrals made to Telehomecare from the community sector from current level.

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Referral processes to Education and Self-Management Programs are not consistent across Providers.	▪ Referrals made to the Diabetes Education Programs will be transferred to a designated community organization.
Lack of physician support and engagement for LHIN initiatives relating to chronic disease management.	▪ The Chronic Disease Management team in the Central West LHIN will develop a focused strategy for physician engagement. ▪ The team will work with its' Core Action Group and the Primary Care Network to foster communication and knowledge transfer between stakeholders.
Impact of chronic disease self-management may not be fully realized in short-term utilization outcomes.	▪ The LHIN will focus on measuring performance in ways that allows gradual improvements to be identified and monitored over time through its balanced scorecard and indicator dashboards.

Key Enablers

The LHIN will continue to develop partnerships with professional practice groups, primary care providers, FHTs, the five Health Links, Telehomecare and other organizations involved in the care of residents living with chronic diseases including diabetes and CHF. These partnerships are key to improving coordination and knowledge transfer across HSPs.

2.3 Improve Access to Mental Health and Addictions Services

IHSP Initiative Description

The LHIN is working with community partners to increase capacity for community-based programs and to improve early intervention for youth-at-risk. This work aligns with *Ontario's Comprehensive Mental Health and Addictions Strategy* and its focus on children and youth.

Current Status

The Central West LHIN funds eight HSPs that deliver mental health and addictions services to over 2,600 local residents each year. Services range in function, intensity and duration and include case management; crisis response, counselling and treatment, early intervention, support within housing, residential withdrawal management, diversion and court support, social rehabilitation, recreation, health promotion and employment support.

In 2013/14 the Central West LHIN made notable investments in community mental health services. New base-funding was allocated to short-term case management for mental health and addictions, thereby increasing the number of practitioners delivering front-line care. In April 2013, following recommendations laid out in Ontario's "*Open Minds, Healthy Minds – A three year plan for children and youth mental health*", five Mental Health Nurses were introduced, through the Central West CCAC, into area public schools. The program serves students aged four to 21 years living with a mental health or addictions issue and who are registered in a public school system. In addition, Nurse Practitioners were added to the Eating Disorders Clinic team, managing 156 new referrals last year, 70% percent of whom were under 24 years of age.

Standardized crisis plans and protocols were developed to prevent and better manage crises by the local mental health and addictions services collaborative. A new service resolution model was introduced to clients with complex circumstances, with a focus on youth and young adults aged 16 to 24 years.

Despite these investments, mental health and addictions services within the community remain under-resourced. Continued investment is warranted. The number of ED visits for mental health and substance abuse continues to rise, particularly for stress, anxiety disorders and alcohol use. Residents in the Central West LHIN make up five percent of active admissions to

Ontario's mental health units, with mood disorders and schizophrenia accounting for the largest proportion of hospitalized patients. Average wait times for mental health case management, counselling/treatment, early intervention, diversion and court support, addiction services and supportive housing services offered within the LHIN are longer than most areas of the province.

Alignment with Government Priorities

Improving mental health services, throughout the lifespan, is one way to ensure all Ontarians receive better access, better quality and better value from their healthcare system. The initiatives and outcomes that the LHIN is pursuing are clearly aligned to *Ontario's Action Plan for Health Care* and the *Open Minds Healthy Minds* mental health and addictions strategy. Through early identification and intervention with at-risk youth and enhanced community-based services, the LHIN is working to ensure that residents with mental health and addictions receive timely access to the most appropriate services as close to home as possible.

Action Plans/Interventions	2014/15	2015/16	2016/17
Working with local providers, plan and implement the local Narcotics Strategy, including utilization of Ontario Telemedicine units.	In Progress 40%	Ongoing	Ongoing
Execute the local work plan to reduce repeat emergency department visits within 30 days for mental health and substance use.	In Progress 40%	10%	Ongoing
Adopt, execute, and monitor a coordinated access model for mental health and addiction services.	In Progress 40%	20%	Ongoing
Lead the development a LHIN-wide strategy to improve age-appropriateness of services for youth and capacity to intervene earlier.	Not Yet Started 60%	40%	

Expected Impacts of Key Action Items

By acting on these initiatives, more residents with mental health and/or addiction issues will have faster access to the mix of services which meet their individual needs closer to home. More children and youth will receive services integrated with their school setting; more clients will have access to collaborative multi-disciplinary care; and fewer residents will require care in ambulatory and inpatient settings.

Outcome Metrics:

- Reduce the number of repeat, unplanned emergency visits within 30 days for mental health conditions to MLPA target.
- Reduce the number of repeat, unplanned emergency visits within 30 days for substance abuse to MLPA target.
- Reduce the rate of unplanned emergency visits for mental health and substance abuse conditions among youth aged 15-24 years by 10% by the end of 2015/2016.
- Decrease the median wait time for mental health case management to 30 days by 2015/2016.

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Existing structures and jurisdictional boundaries may not facilitate the change management required to meet the needs of the youth and young adult population.	▪ The LHIN will facilitate and monitor discussions amongst providers of children and adult services to share expertise and align structures, priorities and funding that support system transformation.
Health service providers' capacity to respond on a timely basis along with individual's readiness/willingness for treatment can preclude the LHIN's ability to reduce ambulatory visits for substance conditions.	▪ Health service providers in the LHIN understand the nature of addictions and help-seeking behavior. Discussions will continue amongst providers around creating and sustaining models of service which are more responsive to residents at all stages and locations where help is sought.
Program implications and associated costs with implementing coordinated access models for mental health and addictions may be prohibitive to justify executing preferred care models.	▪ The LHIN will continue to monitor and learn from the costs and considerations incurred in other LHINs undergoing similar processes. ▪ The choice of access models put forward to the Board and the MOHLTC will be feasible and scalable.

Key Enablers

The LHIN is committed to increasing the capacity of community-based services for mental health and addictions and to sustaining this commitment to both hospital and community mental health and addiction service providers and relevant child and youth serving agencies. The LHIN will continue to align funding with the province's Comprehensive Mental Health Strategy and to work with the local Service Collaborative to implement system transformations that improves mental health and well-being for the residents within the Central West LHIN.

2.4 Improve Access to Community-Based Services for Seniors

IHSP Initiative Description

With the aim of reducing avoidable ED visits, hospital admissions and Alternative Level of Care (ALC) designations, the LHIN is working with community partners to develop strategies that support seniors in the community and increase their quality of life.

Current Status

The Central West LHIN funds 21 community-based agencies that deliver services to support the independent living of seniors within the community. Services include delivery, social/safety visiting, congregate dining, adult day programs, transportation, exercise/falls prevention, chronic disease management, caregiver support, independence training, psychogeriatrics, assisted living, respite and palliative care. The LHIN also provides funding to the Central West CCAC to deliver nursing care, rehabilitation and personal support services, as well as rapid response nursing care, palliative care, community clinics, supportive living and long-term care placement.

In 2013/14, the Central West LHIN invested $11.2 million in funding to support home care and expanded community health care services for more seniors. Notably, $3.5 million in allocations resulted in the addition of 205 assisted living spaces in Shelburne, Orangeville, Brampton, north Etobicoke and west Woodbridge, representing a 48% percent increase in the number of funded places. Investments in adult day programs increased the number of funded places in two existing programs, and two sites expanded services to provide weekend coverage.

The Alzheimer Society of Dufferin County and Alzheimer Society of Peel received funds to expand joint "First Link" programs which support individuals and their families living with dementia. The Central West CCAC assumed management of all assessment, referral and waitlist processes for assisted living and adult day programs operating within the LHIN's boundaries.

Enhancements were made to Assess and Restore units at Headwaters Health Care Centre and Brampton Civic Hospital by purchasing equipment and adding care coordination capacity. In addition, the Nurse-Led Outreach Team (NLOT) received funding which supported the increase in the annual volume of Long-Term Care (LTC) home residents served. The availability of NLOT to support LTC homes has reduced the rate of unscheduled ED visits among active residents and ED visits resulting in hospital admission, by five percent since the program's inception.

Last year the Province of Ontario announced further investments in annual base-funding to support enhanced access to physiotherapy. Improvements to physiotherapy services include expansion of exercise and falls prevention classes, in-home physiotherapy, physiotherapy clinics, services in LTC homes and primary care integration. In 2014/15, the LHIN will expand exercise and falls prevention, while the MOHLTC will manage implementation of other areas of physiotherapy reform. The Central West CCAC will coordinate implementation of 149 exercise and falls prevention classes across 49 sites in the Central West LHIN. Specifically, the Central West LHIN will provide the Central West CCAC with a base funding allocation of $1.3 million to expand home physiotherapy services for 2,036 additional physiotherapy clients, and $448,200 to implement 149 exercise and falls prevention classes in 36 locations across the Central West LHIN, enabling seniors and eligible patients to stay healthy, active and independent in their own homes and local communities. In addition, the MOHLTC will invest more than $2.35 million to support the addition of new publicly-funded community physiotherapy clinics.

Since its inception, the Behaviour Supports Ontario (BSO) program has interacted with over 8,000 LTC home residents, helping staff to develop individual care plans, avoid unnecessary visits to hospital EDs and hospital admissions. In addition, the rates of LTC home assessments that trigger worsening behavioural symptoms has declined, with a noted significant decline in the reported use of physical restraints. By the end of 2013/14 the BSO program had trained over 7,300 front line staff in the recognition and care of people exhibiting responsive behaviours.

74% percent of senior residents who were hospitalized last year were discharged to home-based settings, a reflection of the Central West LHIN's investments in Central West CCAC and community-based services. However, there is room for improvement. Seniors continue to account for high utilization of hospital services in the LHIN, comprising 17% percent of ED visits, 27% percent of hospital admissions and 81% percent of ALC days. Residents also wait too long in EDs - one in 10 seniors are waiting 40 hours or more from the time they present in the ED until admission to an inpatient bed.

In 2014/15, the Central West LHIN will continue to develop a local Seniors Strategy based on recommendations made in Dr. Samir Sinha's *Living Longer, Living Well* report, feedback from local community engagement sessions held in 2013/14, key informant interviews, the LHIN's environmental scan and findings of a community capacity study currently underway.

Alignment with Government Priorities

The LHIN's initiative to improve access to, and funding for, community-based services for seniors is fully aligned with *Ontario's Action Plan for Health Care* which encourages the development of local seniors strategies which focus on supporting seniors to stay healthy and stay at home longer. The LHIN's Seniors Strategy is being developed based on the five principles outlined in Dr. Sinha's *"Living Longer, Living Well"* Report: *Access, Equity, Choice, Value and Quality.*

Action Plans/Interventions	2014/15	2015/16	2016/17
Complete a local Capacity Study to determine the optimum number and mix of resources required to support community-based living for seniors.	In Progress 100%		
Utilize results from the local Capacity Study to inform future funding allocation for adult day, assisted living and long-term care spaces required to serve the residents of Central West.	Not Yet Started 100%	Ongoing	Ongoing
Finalize the Central West LHIN Seniors Strategy based on provincial recommendations made in *Living Longer, Living Well.*	In Progress 100%		
Develop business plans to increase availability of local sub-acute and geriatric rehabilitative care programs; support development of assess and restore options.	In Progress 40%	Ongoing	Ongoing
Fully integrate the new and existing community nursing models (e.g. GEM nurses, Nurse led Outreach Teams, Rapid Response Nurses, Palliative Care Nurses and Telehomecare nurses) to support transitions.	In Progress 25%	25%	On-going
Explore the feasibility of expanding the NLOT program into the Assisted Living environment. If deemed feasible, develop a Business Case that describes operations, sponsorship and funding of the program.	Not Yet Started 100%		

Expected Impacts of Key Action Items

The Central West LHIN will continue its work to improve access to and the availability of community-based services that support seniors to be healthy and active within their communities, while reducing the use of hospital-based service. More adult day and assisted living services will be added in the LHIN, guided by the needs and demographics of local residents and the availability of funding to improve transitions for seniors as they navigate through the health care system.

Outcome Metrics:

- Reduce the number and proportion of hospital days stayed on an alternate level of care (ALC) among seniors discharged from acute inpatient beds from current levels.
- Increase the proportion of seniors discharged to home settings from local EDs and inpatient beds from current levels.
- Meet MLPA target for 90th percentile wait time for CCAC in-home services from the community setting.
- Establish a baseline and set targets for the low and moderate needs clients referred by CCAC to Community Support Services.

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
High rate of growth occurring among the seniors population in the Central West LHIN puts increasing pressure on the demand for, access to, and supply of local health services.	▪ Continue to monitor senior's population growth and utilization impact. ▪ Develop a comprehensive local Seniors Strategy using the LHIN's environmental scan, results of the Community Capacity Planning study and community engagement sessions to guide service allocations.
Limited supply of specific health care professionals and their interest in practicing in community-based settings (e.g. nurse practitioners) may affect the ability of health service providers to staff funded programs (e.g. NLOT, Palliative Care).	▪ Support local partners in recruitment efforts.
Lack of high quality, timely data on service utilization specific to seniors.	▪ The LHIN will focus on measuring performance using sources and indicators that captures improvements specific to the seniors population. These indicators will be monitored and tracked through use of a Senior's Performance Dashboard. ▪ Agreement on additional data elements and indicators will be submitted to the LHIN by individual Health Service Providers.
Recognizing the cultural diversity of resident demographics in the Central West LHIN, culturally-appropriate approaches to service delivery must be considered if seniors are to live successfully in home-based settings.	▪ The Health Impact Assessment Tool will be used to evaluate barriers to accessing care for seniors. ▪ Feedback from community engagement sessions, Health Equity Plans and input from Health Service Providers, with expertise in serving diverse seniors communities, will be used to monitor and promote cultural awareness.

Key Enablers

Building on strong partnerships with the Central West CCAC, LTC homes, the five Health Links, local hospitals and community partners, the LHIN will continue to support and invest in efforts that improve access to community-based services for seniors. Fundamental to supporting system performance and keeping senior residents out of institutional and acute care settings, is the active participation of the Core Action Group and use of utilization data that is specific to seniors.

Streamline Transitions and Navigation of the System

2.5 Improve Linkages With and Among Primary Health/Family Health Care and other Providers in the Health Care System

IHSP Initiative Description

The LHIN will increase coordination of Central West CCAC care in primary care settings to ensure the provision of the right community-based care. The LHIN will continue to focus on populations with complex needs, who access care from multiple providers or are disadvantaged, marginalized and struggle to get the care they need, when and where needed.

Current Status

In 2013, the LHIN played a leadership role in establishing five Health Links that encompass all communities across the entire geographic area including Bolton–Caledon, Bramalea and Area, Brampton and Area, Dufferin Area and North Etobicoke-Malton-West Woodbridge.

In support of Health Links, the Central West LHIN approved funding for six Care Coordinators managed through the Central West CCAC, to develop and implement coordinated care plans for identified high use residents. The Central West CCAC is developing additional strategies to increase alignment and coordination between primary care settings. While focused on collaborative care planning for the complex health needs of clients who utilize significant resources from multiple HSPs, these strategies will help to improve care for all clients.

In 2014/15, Central West LHIN Health Links will seek to identify and develop individualized coordinated care plans for each identified high use resident, leveraging local resources and information across the continuum of care. In addition, Health Links will continue to extend their reach through increased community and provider awareness and engagement with the aim of providing better care for complex patients.

In 2013, the Central West LHIN also became one of three LHINs to pilot the provincial Telehomecare project. The aim of the Telehomecare program is to electronically link patients who have complex chronic conditions with a nurse, who can then remotely monitor and rapidly respond to changes in health information. The Telehomecare program has received 1,620 new referrals, 565 clients have been enrolled and 198 clients have been discharged. In 2014/15, with the aim of becoming a supportive self-management tool for complex residents, the Telehomecare program will align with Health Links and the identification of high use residents.

The LHIN and CHCs are continuing to adopt and integrate findings from the Health Equity Impact Assessment (HEIA) Analysis. This work is reducing barriers to access for individuals with cultural and language needs, low income, mental health and addiction issues, unstable housing, social isolation and sexual/gender diversity.

Alignment with Government Priorities

Two goals of *Ontario's Action Plan for Health Care* are to have a family health care provider for every Ontarian who wants one and, to provide more patients with faster and more convenient access to this care. Health Links will encourage greater collaboration among existing local health care providers. With improved coordination and information sharing, identified residents will receive faster care, will spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.

Action Plans/Interventions	2014/15	2015/16	2016/17
Reduce the wait time from primary care referral to specialist consultation for complex patients.	Not Yet Started 80%	20%	Ongoing
Reduce the number of 30-day all-cause readmission to hospital for high users in the Central West LHIN.	Not Yet Started 70%	30%	Ongoing
Ensure each individual identified as a high-user has a care plan which encompasses Health Link partners across the continuum of care.	In Progress 60%	40%	Ongoing

Expected Impacts of Key Action Items

By the end of 2014/15, all identified high users within the LHIN will have active coordinated care plans. Residents with complex needs will face shorter wait times for specialty services and face fewer readmissions to hospital following stabilization.

Outcome Metrics:

- All clients enrolled with Health Links will have coordinated care plans.
- Establish baseline and targets for 50th percentile and 90th percentile wait time from time of referral to first consultation with a specialist (by specialty).
- Establish baseline and set targets to reduce the rate of 30-day all-cause readmissions to hospital for enrolled Health Link patients.
- Establish base-line and set targets to reduce the rate of emergency department and inpatient visits for enrolled Health Link patients.

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Projected population growth of LHIN residents will increase demand on the supply of, and access to, primary care practitioners in the LHIN	▪ Continue to utilize and monitor referral patterns to primary care through Health Care Connect. ▪ Monitor physician supply, recruitment and, model adoption through the LHINs Health Force Ontario Community Partnership Coordinator. ▪ Monitor referral patterns to Health Links for barriers to access and for growth in demand.
Access to and communication of relevant patient information across Health Service Providers impedes timely access to care	▪ The LHIN will continue to adopt and support the use of eHealth infrastructures that improve the availability and transferability of client-based information.

Key Enablers

Building on strong partnerships with local Family Health Teams, Community Health Centres, the five Health Links and the Central West Community CCAC, the LHIN will continue to support and invest in efforts that forge relationships, improve information exchange and patient transitions between primary care, acute care and community service partners.

2.6 Improve System Navigation Resources

IHSP Initiative Description

The LHIN is working with community and hospital-based providers to understand and better address barriers to system access. The LHIN is also working with providers to develop integrated care pathways and care plans to help understand where and when to access needed health care after discharge from hospital. The LHIN will partner with community and government agencies to strengthen system navigation and support the establishment and use of services, such as Health Links and Telehomecare.

Current Status

In 2013/14, the Central West LHIN Patient Flow Core Action Group (CAG) was formed with the mandate to identify strategies and recommend actions surrounding capacity planning, knowledge translation and issues of transition/navigation management. Strides have been made to improve hand-offs between hospital care and community agencies through adoption of the "Home First" philosophy, implementation of Aging at Home initiatives and the introduction of Telehomecare and Health Links. The LHIN's five Health Links began to improve care for seniors and residents with complex conditions through the use of personalized care plans and more coordinated support from an integrated team of HSPs.

Several barriers to access were addressed. The Central West CCAC assumed responsibility for the assessment and placement of clients in eight adult day programs and six assisted living programs operating in 18 locations across the Central West LHIN. Three agencies received community funding to increase transportation services. Outpatient rehabilitation services remain limited for LHIN residents and the number of patients discharged home following hip and knee replacement surgery has declined. The LHIN continues to explore best practice pathways for rehabilitation care to support recovery within the community.

Alignment with Government Priorities

The Central West LHIN is committed to ensuring residents receive better access to care in the most appropriate settings. These priorities are reflected in the Central West CCAC's expanded role of waitlist management, the ongoing support for Home First and the implementation of Health Links. The Action Plans are focused on integrating local health care while reducing and eliminating barriers to service.

Action Plans/Interventions	2014/15	2015/16	2016/17
Develop and implement post-acute/post-discharge care plans for Adult Day Programs, Assisted Living and Respite services.	In Progress 50%	Ongoing	Ongoing
Develop integrated best practice rehabilitation care pathways and care plans for patients discharged from hospitals	Not Yet Started 50%	50%	Ongoing
Implement recommendations from the LHIN's Transportation Study to improve productivity and meet activity targets.	In Progress 25%	Ongoing	Ongoing
Work with local providers to develop integrated care pathways and care plans to assist residents in navigating the system after discharge from hospital.	Not Yet Started 33%	33%	33%
Develop and implement Health Link Care Coordination plans for Telehomecare clients.	Not Yet Started 50%	25%	25%

Expected Impacts of Key Action Items

All prospective clients for assisted living and adult day programs will be assessed and placed by the CCAC through implementation of a centralized wait list. Recipients of adult day programming, assisted living services and respite will have care plans that help them navigate the care and supports they need after discharge.

Outcome Metrics:

- Meet MLPA target for 90th Percentile wait time for CCAC in-home services from the community.
- Meet MLPA target for rate of readmissions within 30-days of discharge for select case-mix groups.
- Increase the number of clients enrolled in the Telehomecare program to date to 1,000 by 2015/16.
- Increase the number of patients discharged home following hip and knee replacement to 90%.

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Barriers to access may require pan-LHIN discussion and/or provincial support. Cross-ministerial issues may be identified that cannot be resolved without collaboration.	▪ The LHIN will work with local Health Service Providers, neighbouring LHINs, and the Ministry of Health and Long-Term Care to identify any barriers and explore opportunities.
Resources and/or funding are not available to sustain program and process improvements. In particular, current funding for the Telehomecare Program is set to end in Q3 2014/15.	▪ The LHIN will establish routine status updates with Health Service Providers and report on ongoing processes. ▪ The LHIN will develop a business plan to sustain the operation of the Telehomecare program.
Lack of data and capability to link episodes of care and monitors residents' transitions within and across the health care system.	▪ The LHIN will focus on monitoring and tracking readily-available performance indicators that reliably capture resident transitions. ▪ The LHIN's Decision Support Unit will continue to work with its counterparts at the local and provincial level to establish, link and use appropriate data sets.

Key Enablers

Dr. Sinha's *"Living Longer, Living Well"* report calls for the development, linkage and implementation of innovative care models within and beyond the acute care setting if Ontarians are to remain independent and age in place. These innovative care models require clear identification of processes, timelines, objectives, and accountabilities; buy-in and support from all HSPs and LHIN staff; allocation of time and resources for staff engagement, training, and standardization; and access to timely information to improve communication and collaboration.

2.7 Increase System Collaboration through the use of Information Technologies

IHSP Initiative Description

The Central West LHIN will continue to lead and participate in provincial, regional and local initiatives that support the development of an Electronic Health Record (EHR) for all Ontarians. The EHR is designed to contain and share information from all providers involved in a patient's care. The LHIN will work with hospitals and primary care practitioners to ensure timely discharge information is accessible.

Current Status

In 2013/14 the Central West LHIN made significant strides with respect to Information Management, implementing the Community Care Information Management's (CCIM) common assessment tools, screener tools and Integrated Assessment Record (IAR) in many local HSPs. Use of these tools allows personal health information to be transferred securely between HSPs, reducing the workload of agencies and effort of clients. Monthly summary reports available since October 2013, have allowed the LHIN to better understand select client populations and to begin monitoring strengths and gaps in system services.

Headwaters Health Care Centre continues to expand electronic access of their hospital reports to primary care physicians and specialists through the use of the Hospital Report Manager (HRM) product. William Osler Health System (Osler) will implement HRM in fiscal 2014/15 and plans to share access to their reports with primary care physicians. Osler, Headwaters, the Central West CCAC and most LTC homes have now implemented provincial referral standards for hospital (acute inpatient) to Central West CCAC referrals and hospital (acute inpatient) to LTC referrals, under the direction of the Provincial Alternative Level of Care Resource Matching & Referral Business Transformation Initiative (RM&R BTI).The need for a Central Intake process has been identified as a barrier to access by multiple providers and client populations within the LHIN.

Adoption of physician Electronic Medical Record EMR systems continues to be a focus for the LHIN. 87% percent of primary care practitioners and 51% percent of specialists have now adopted the use of EMR systems - the highest adoption rates in the province. The Ontario Lab Information System (OLIS) has collected approximately 70% percent of provincial lab test results through connections with hospitals, community labs and public health labs. Osler is now providing OLIS with ongoing test results, while planning continues for Headwaters to follow suit.

250 clinicians in the Central West LHIN can now view OLIS data for their patients in their EMR systems. An additional 290 clinicians are completing activities required to view their patient lab data and others will be connected throughout the year.

The Connecting GTA (cGTA) project continues to work with health care providers to provide a single point of access to patient health information. At the end of 2013/14 Osler continued to feed data into the clinical repository. Viewing of patient data within the cGTA repository is targeted for 2014/15. Headwaters is a strong contender to be included in the next wave of onboarding. Thirteen HSPs and community partners across the Central West LHIN have been short listed to view patient data with the cGTA repository.

Alignment with Government Priorities

A key component of *Ontario's Action Plan for Health Care* is to achieve greater exchange of electronic information across Ontario's health system. The MOHLTC, in partnership with eHealth Ontario, has set an ambitious strategy to implement an Electronic Health Record (EHR) by 2015. Participation in cGTA, OLIS, Hospital Report Manager, physician EMR adoption and the Care Coordination Tool are necessary requirements to support implementation of the EHR. Innovative electronic health system solutions must be adopted to support integration of information in and across community service agencies. Such systems include the Integrated Assessment Records and Care Coordination Tools, slated to be adopted by the five local Health Links.

Action Plans/Interventions	2014/15	2015/16	2016/17
Expand implementation of Hospital Report Manager.	In Progress 40%	10%	
Increase local adoption of Physician EMRs.	In Progress 16%		
Continue to implement the IAR in the LTC sector.	In Progress 15%	Ongoing	Ongoing
Implement Clinician view and hospital lab results feed to the Ontario Lab Information System (OLIS).	In Progress 30%		
Implement the Connecting GTA – Provider Portal and Health Information Access Layer (HIAL).	In Progress 25%	30%	20%
Implement the Resource Matching and Referral BusinessTransformation Initiative Provincial Referral Standards.	In Progress 33%		
Conduct a Central West LHIN IT/IM Environmental Scan of local health service providers.	Not Yet Started 100%		
Develop and Implement a Central Intake Solution	Not Started 25%	75%	
Develop and Implement a Standardized Discharge Summary	Not Started 25%	75%	

Expected Impacts of Key Action Items

By the end of 2015/16, primary care practitioners working in the Central West LIN will have more timely access to their patient's clinical reports, lab results and discharge summaries. This will enable quicker identification of diagnoses, treatments and service gaps. All health service providers will see improved electronic sharing of and access to patient information.

Outcome Metrics:

- Increase the number of local users actively searching the IAR from current levels.
- Increase the number of referrals sent electronically across HSPs from current levels.
- Increase the number of lab results accessible by clinicians working in the LHIN through OLIS from current levels.
- Increase the number of hospitals and physicians using the HRM platform.
- Increase the percentage of primary care practitioners and specialists who have implemented an EMR.
- Increase the numbers of clinicians working in the LHIN whose EMRs are connected to OLIS.
- Increase the number of hospital reports transmitted electronically from hospitals to physician EMRs.

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Health Service Providers have limited physical, capital and human resource capacity to implement, sustain and monitor IT/IM solutions.	▪ The LHIN will facilitate ongoing dialogue with Health Service Providers to understanding their priorities and capabilities and align activities where possible. ▪ Identify a champion health lead for each IT/IM project. ▪ The LHIN will continue to build stakeholder awareness, engagement and buy in for IT/IM solutions as early as possible. ▪ Ensure that a sustainability model is created and communicated to the HSPs and to the LHIN in advance of committing to project implementation.
Funding allocated for IT/IM projects does not cover all costs that Health Service Providers incur to on-board and implement.	▪ The LHIN will ensure that all costs to be borne by Health Service Providers for IT/IM projects are known and communicated up front. ▪ The LHIN will identify and communicate quantifiable benefits of IT/IM projects up front. ▪ The LHIN will communicate potential unrecoverable project costs to Health Service Providers in advance of obtaining their commitment.
Uncertainty regarding government priorities for IT/IM may impact engagement and participation of health care system stakeholders and champions.	▪ Commitment to government priorities will be reinforced through stakeholder engagement and communications. The LHIN will ensure timely communication of all priority information.

Key Enablers

Information technologies and information management are key enablers to achieving the Central West LHIN's four strategic directions outlined in IHSP 3. To implement these projects successfully, the timely release of funds by both the MOHLTC and the LHIN is imperative. Accountabilities and responsibilities must be clear among stakeholders and change management practices/tools should be in place to support effective adoption. Ongoing partnerships with neighbouring LHINs, delivery partners and health service providers will enhance the ability to leverage regional solutions and sustainability models must be created and communicated to the health service providers and the LHIN in advance of committing to project implementation.

Drive Quality and Value

2.8 Ensure an Overarching LHIN Quality Framework

IHSP Initiative Description

The Central West LHIN supports the establishment of education and training programs aimed at improving treatment, care and safety based on leading practices, while building capacity for improvement and safety. The LHIN will incorporate patient/client experience in quality indicators, and develop a collaborative and integrated approach with HSPs to support the development of quality improvement plans and to undertake accreditation processes.

Current Status

In 2013, the Central West LHIN Board of Directors identified quality as an important focus in its governance role. A Quality Committee of the Board was established to provide oversight for local health system quality. This role includes the development of system-level aims for improvement and monitoring progress towards the achievement of these aims through a quality dashboard as part of the LHIN's Balanced Scorecard. The LHIN's role in performance monitoring through the Balanced Scorecard and associated dashboard provides an overview of the status of the local health care system relative to important indicators of quality, aligned with the four strategic directions of IHSP 3. The Quality Committee also provides guidance for implementation of the Central West LHIN Quality Framework. The framework provides a foundation for the development and implementation of targeted cross-sector initiatives designed to build capacity for improvement of quality and safety.

In 2014/15 the LHIN will focus on understanding and improving residents' experience through the identification of processes and indicators that can help to capture patients'/clients satisfaction with different parts of the local health care system. Health Links, Central West CCAC and the two CHCs are slated to develop experience indicators in 2014/15.

The Central West CCAC, Headwaters Health Care Centre, William Osler Health System, Bramalea CHC and Rexdale CHC all completed Quality Improvement Plans (QIPs), submitting them to Health Quality Ontario (HQO) by March 31, 2014. The MOHLTC expanded requirements for LTC homes to submit their QIPs by April 1, 2015 for fiscal year 2015/16. The Central West LHIN will continue to request submission of QIPs from HSPs for review and discussion. Opportunities for greater collaboration and integration of objectives and activities associated with QIPs will be explored.

In addition to QIPs, accreditation is an important process for all LHIN-funded agencies to undertake to identify areas of excellence and where gaps exist relative to quality standards of care. In 2013/14, a majority of LHIN HSPs were either in the process of becoming or were already accredited. The Central West LHIN hosted an Accreditation Workshop in January 2014 to support non-accredited providers in understanding the accreditation process. The 16 non-accredited community-based providers are in the process of creating and submitting their QIPs. The LHIN will subsequently consider the resources and supports required for successful completion of the accreditation process, with the expectation all providers will be accredited by March 31, 2017.

Alignment with Government Priorities

The LHIN is committed to providing leadership for quality in support of the Excellent Care for All Act (ECFAA) and *Ontario's Action Plan for Health Care*. The LHIN's Quality Framework supports the principles of ECFAA and its development has been guided by the attributes of a high-performing healthcare system, defined by Health Quality Ontario. These attributes reflect a system that is: accessible, effective, safe, patient-centred, efficient, integrated, equitable, population-health focused and appropriately resourced. *Ontario's Action Plan for Health Care* builds on the ECFAA by setting clear directions for patient's to receive the right care, at the right time and in the right place.

Action Plans/Interventions	2014/15	2015/16	2016/17
Implement the Board Quality Committee's on-going work plan aligned to its Terms of Reference including monitoring and reporting on local health system quality.	Ongoing	Ongoing	Ongoing
Complete, consult and disseminate the Central West LHIN Quality Framework to all relevant stakeholders.	In Progress 100%		
Implement the Central West LHIN Quality Framework including identification of system level aims for improvement, alignment of existing initiatives and planning of new initiatives/projects, and integration of quality improvement plans and methodologies.	In Progress 50%	50%	Ongoing
Promote and integrate provincial and regional quality improvement processes, tools and resources (IDEAS, BestPATH) to support learning and exchange among Central West HSPs.	In Progress 50%	25%	Ongoing
Support completion of Quality Improvement Plans (QIPs) as part of accountability agreements and existing or anticipated MOHLTC requirements related to ECFAA with particular attention to community-based HSPs.	In Progress 50%	50%	Ongoing
Support completion of accreditation processes for all community-based HSPs including documentation of accreditation status and planning for completion for any non-accredited organizations as part of their accountability agreements.	In Progress 40%	40%	20%

Expected Impacts of Key Action Items

By March 31, 2017, all Health Service Providers within the Central West LHIN will have achieved accreditation and organizational Quality Improvement Plans will be aligned with the Central West LHIN's Quality Improvement Framework and system-level aims. As a result, more residents will receive safer, accessible, evidence-based, integrated, patient-centred care.

Outcome Metrics:

Monitor LHIN rates of *:

1) Hospital Standardized Mortality Ratio (HSMR)
2) In-hospital fractures
3) Hospitalizations for falls among long-term care residents
4) Restraint use in long-term care homes
5) Clostridium difficile Infection (CDI)
6) Methicillin Resistant *Staphylococcus aureus* (MSRA) Bacteremia
7) Vancomycin Resistant *Enterococcus* (VRE) Bacteremia
8) Central Line-Associated Primary Bloodstream Infection (CLI)
9) Ventilator-Associated Pneumonia (VAP)

** Performance below established and LHIN/H-SAA targets defined in the 3-year Balanced Scorecard will trigger follow-up and intervention.*

- Monitor the LHIN's Quality Dashboard on a quarterly basis for progress towards achievement of system level aims.
- Establish resident experience indicators across Health Link partners to measure performance related to integration and patient-centeredness.
- Increase the number of HSPs that have developed and implemented Quality Improvement Plans from current levels, according to the provincial roll-out timeframes.
- Increase the number of HSPs from the community sector that are accredited from current levels.

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Provincial and regional stakeholders may face competing demands, duplication or inconsistency related to initiatives designed to support quality improvement.	▪ The LHIN Quality Framework will be disseminated LHIN-wide to all relevant stakeholders. The LHIN will also consult with Health Service Providers and stakeholders on opportunities for greater alignment and collaboration on quality objectives and priorities.
Variation in the capacity of HSPs to commit the required time and resources at governance, clinical and administrative leadership and front-line levels to drive improvements in quality.	▪ The LHIN will work with Health Service Providers with limited support to develop strategies for increasing capacity for quality improvement and facilitate uptake of provincial training and coaching support including application of Central West teams to IDEAS and associated projects.
For some smaller Health Service Providers, completion of accreditation may require resources that exceed their capacity (i.e., lack of funding, human resources).	▪ The LHIN will work with Health Service Providers to support accreditation efforts including review of funding requests and support for strategies that build organizational capacity for the completion of the accreditation process.
Access to appropriate data for measuring and reporting on improvement.	▪ The LHIN will continue to work with available data sources and with Health Service Providers to obtain, review and use data including developing indicators that measure residents' experience.

Key Enablers

The Central West LHIN has the opportunity to drive improvement in safety through the development of an overarching framework for quality. To do so, collaboration, alignment and coordination of strategies among the Central West LHIN, its Board of Directors and funded agencies are needed to optimize the impact of improvement efforts. Expertise, resources, the sharing of best practices and acknowledgement of success are necessary to advance a culture of continuous quality improvement.

2.9 Optimize Use of Health Care Resources to Foster Better Value

IHSP Initiative Description

The LHIN is working to reduce avoidable hospital admissions by supporting expanded community-based services. The LHIN is also reducing ALC designations by seeking improvements in discharge processes and supporting community-based services. The LHIN will work with local providers about improving admission, bed utilization, and discharge processes. Additionally, the LHIN will implement HSFR initiatives with the MOHLTC and local HSPs to support best practice, cost-effective treatment and care.

Current Status

The Central West LHIN has the highest proportion of high acuity ED visits in the province. In 2013/14, 79% percent of all ED visits were triaged as high acuity, compared to 65% percent for the province. 12% percent of all ED visits and 16% percent of the high acuity ED visits resulted in an inpatient admission. The LHIN has met provincial ED wait time targets for low-

acuity patients, discharging 90% percent of patients within four hours or less of presentation and 90% percent of high acuity patients within eight hours. These improvements are largely attributable to the Pay for Results program, which was in its sixth year in 2013/14, and targets improvements in ED processes.

Patient flow through the rest of the hospital still has room for improvement. Patients whose ED care results in admission to an inpatient bed continue to wait too long in local EDs. The average wait time in 2013/14 was 14 hours, and one in 10 patients waited 22 hours or more until from the time they were triaged until they were assigned an inpatient bed. The number of patients processed through the system without being designated as ALC continues to increase, while the number of patients being discharged with an ALC designation is declining. In 2013/14, 1,411 patients were designated ALC in the Central West LHIN. 1,495 ALC-designated patients were discharged, accumulating a total of 31,337 ALC days. Although the Central West LHIN maintains one of the lowest rates of inpatient capacity lost to ALC, we continue to work toward avoiding and reducing ALC designations.

A focus of the Patient Flow Core Action Group (CAG) at the LHIN is to reduce avoidable hospital admissions from both emergency departments to inpatient units and from acute to post-acute beds. A proxy measure to track these admissions is ALC designations within two days. There are few conditions which require a hospital stay of two days or less. These tend to be relatively routine episodes of care for young and healthy people, such as childbirth or minor surgeries, and those conditions are much more likely to result in an unfettered discharge. When a patient is designated ALC within two days of having been admitted to an inpatient bed, there is a strong likelihood that the admission was not clinically necessary. The rate of patients designated ALC within two days has grown from a low of nine percent in Q3 of 2012/13 to 16% in Q3 2013/14.

In 2013/14, funding for selected surgeries and diagnostic wait times shifted to the new QBP model. Providers are expected to deliver these procedures within funded amounts while maintaining and improving access times. The LHIN has experienced tremendous improvement in wait times for diagnostic imaging—more than 90% receive computerized tomography (CT) within the provincial access target of 28 days. For magnetic resonance imaging (MRI), the Central West LHIN has moved from rates below 20% percent in 2010 and 2011 to performance above 80%percent in 2013/14. More than 90% percent of cancer surgeries and close to 90% percent of cataract surgeries are consistently performed within provincial access targets; however, wait times for hip and knee replacement continue to grow and the number of residents receiving these surgeries within the provincial access target continues to decline. The LHIN has worked with hospitals to improve performance, but the overwhelming demand for these procedures continues to outstrip the supply.

Alignment with Government Priorities

Ontario's Action Plan for Health Care focuses on providing the right care, in the right place and at the right time. Preventing avoidable hospital admissions is better care. By doing so, we improve resource allocation and add value to the system. Reduction of ALC has been a provincial priority since launch of the provincial ER/ALC strategy in 2009. Improving patient flow and reducing barriers to discharge result in more patients receiving the care they need, when and where they need it.

Action Plans/Interventions	2014/15	2015/16	2016/17
Develop and align the Patient Flow Action Group's work plan on initiatives to optimize patient flow with measurable outcomes.	In Progress 20%	20%	20%
Implement local Health System Funding Reform Partnership.	In Progress 40%	Ongoing	Ongoing
Ensure local alignment to Provincial HSFR roll-out.	In Progress 50%	Ongoing	Ongoing
Create a multi-phased capacity plan by sector, using a demographic and utilization evidenced based methodology.	In Progress 75%	25%	N/A

Expected Impacts of Key Action Items
By the end of 2015/2016, more residents will be admitted from local emergency departments within Ontario's wait time targets. Fewer residents will receive ALC designations during their hospitalization. Outcome Metrics: ▪ Meet MLPA targets for 90th Percentile emergency department length of stay. ▪ Meet MLPA target for percentage of ALC days experienced by patients discharged from acute inpatient beds. ▪ Reduce the rate of ALC designation within 2 days to 10% by 2014/2015. ▪ Meet MLPA target for readmission with 30 days for selected case mixed groups. ▪ Meet MLPA targets for QBP wait time indicators. ▪ Maintain best practice recommendations for average LOS for hip/knee replacement patients discharged home.

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Professional staff does not embrace best practices for quality based procedures; lack of implementation of change plans and/or reversion to old ways of doing things.	▪ LHIN leadership will work with Health Service Providers and the HSFR local partnership to support implementation of QBPs and HSFR funding reform.
Hard-to-place clients are a contributing factor to increasing lengths of stay in regard to ALC designations. Referrals are reportedly denied into LTC due to "Behavioural characteristics".	▪ The LHIN will work with the MOHLTC and local providers to identify opportunities to address access gaps and increase capacity. ▪ Support ongoing use and growth for the Behavioural Supports Ontario (BSO) program. ▪ Using findings from the Seniors Community Capacity Study, the LHIN will evaluate the need to increase Assess and Restore beds and community funding.
Health Service Providers do not achieve performance targets agreed to in their Accountability Agreements.	▪ The LHIN commits to regular meetings and quarterly review of HSP performance to monitor progress and understand current state. ▪ The LHIN is developing a performance management framework to monitor and intervene on performance. ▪ Where needed, HSPs will be asked to develop and implement a Performance Improvement Plan that focuses on the risks of non-performance and problem-solving.

Key Enablers

Clear identification of processes, objectives, timelines, and accountabilities are essential to preventing hospital admissions. Sufficient time and resources allocated for staff engagement, training, and internalization will optimize the impact of improvement efforts. Local understanding and expertise of HSFR processes are needed to successfully implement local funding reform.

Build On the Momentum

IHSP Initiative Description

The LHIN continues to devote time, attention and resources to long-standing initiatives in keeping with the LHIN's legislated requirements that are identified through community engagement and priority-setting. These initiatives are aligned with developing provincial directions and priorities.

Diversity and Health Equity | The Central West LHIN is working with local HSPs at the Diversity and Health Equity Core Action Group (CAG) to identify specific local strategies to engage the diverse communities and to promote equitable access to health care services. This work includes identifying key priorities for action, utilizing tools such as the Health Equity Environmental Scan, the Health Equity Impact Assessment Tool (HEIA), Health Equity Plans, and focusing on culturally competent approaches that improve access to, and the quality of, health care services.

French Language Services | The Central West LHIN will continue to effectively engage local French-speaking communities by working in collaboration with Reflet Salvéo, the French Language Health Planning Entity, with the aim of improving access to and integration of French language health care services in the local health care system.

Aboriginal Health | The Central West LHIN will engage local indigenous people, with the aim of better understanding local health care and service delivery issues so as to further develop priorities and strategies to improve access to and engagement of health care services.

Palliative Care Services | In collaboration with LHINs across the province, the MOHLTC and working locally with the Central West Palliative Care Network, the Central West LHIN will continue to participate in the development of a vision for palliative care across the province. In so doing, the LHIN is in the process of establishing a local plan for palliative care services, tailored to meet the palliative care needs of residents and their families.

Women and Children's Health | The Central West LHIN continues to work with local Health Service Providers and community partners to improve the quality of, and access to, women and children's health services, while at the same time aligning its work with provincial initiatives.

Current Status

The Central West LHIN is an ethno culturally diverse community and a region of increasing income disparity. These characteristics have significant implications for the health of the local population and the health care system. When groups and individuals face barriers to access and receive a lower standard of care, this leads to poorer health, greater strain on limited healthcare resources and ultimately higher costs for worse outcomes.

In 2013/14, partnering with the MOHLTC and the Regional Diversity Roundtable, the Central West LHIN introduced the Health Equity Impact Assessment (HEIA) tool to its funded agencies. Agencies are utilizing this tool to improve program planning for marginalized populations. In addition, the Central West LHIN's Diversity and Health Equity Core Action Group endorsed the use of a cultural competence training module created by SickKids, and funded by Citizenship Immigration Canada. Use of these modules is being integrated into educational curriculum at acute care hospitals.

The Central West LHIN's French Language Services (FLS) Core Action Group has introduced a forum for "identified" French language HSPs to engage on the execution of their Yearly Implementation Plans for the development of French language services. The LHIN worked closely and collaboratively with Reflet Salvéo about engaging the francophone community, capacity building and service planning. Priorities and actions are identified and outlined in a Joint Annual Action Plan between Reflet Salvéo and the Central West, Mississauga-Halton and Toronto Central LHINs. Year-end reporting by each "identified" French Language HSP indicated an increase in the number of Francophone residents who requested services and were served in French.

Members of the indigenous community access services through mainstream providers within the LHIN or travel to Toronto to seek culturally-sensitive services through Anishnawbe Health. In 2013/14 the LHIN partnered with the Peel Aboriginal Network in the planning of the Sisters in Spirit Vigil and participated in the Credit River Métis Council's Louis Riel Day.

The Central West LHIN provides funding to two hospice organizations who serve over 600 palliative clients and their families each year. The Central West Palliative Care Network provides a community for the advancement of hospice palliative care. Network members benefit from a system of communications, strategic planning, and education through a Steering Committee and advisory groups. Members represent hospice palliative care, hospital, Long-Term Care, primary care, community care and education sectors. The Network has introduced the first elements of a Shared Care Model for

hospice palliative care, with Nurse Practitioners and Advanced Practice Nurses supported by a part time Medical Director. Two of five funded Nurse Practitioner positions with the Central West CCAC were filled and a third is expected to be filled in May 2014. Two Advanced Practice Nurses are also available. In 2013/14, the Central West CCAC received 1,585 referral, delivered 2,670 units of service and the palliative shared care nurses diverted 383 palliative patients from visiting local EDs.

The Women and Children's Core Action Group has been working to develop local solutions to close the gap in service coordination for Children with medical complexities. This work will pause in 2014/15 to ensure that local action items are aligned to strategic goals expected from the Provincial Council for Maternal Child Health in 2014.

Alignment with Government Priorities

Addressing health equity is a key strategy for improving the health of the population and the communities in which they live. The LHIN recognizes the culturally diverse and disadvantaged populations it serves and will ensure a Health Equity perspective is built into the planning, funding and implementation of programs. This commitment to health equity is in alignment with the objectives of the MOHLT's strategic direction of equity of access, outlined in the Local Health System Integration Act (LHSIA).

The LHIN provides services to the public in French in accordance with the French Language Services Act (FLSA). In addition, the Local Health Services Integration Act (LHSIA) sets out obligations for the LHIN to engage Francophones to inform health system priorities, actions and performance indicators. French Language Services (FLS) planning entities play a critical role in advising the LHINs regarding local FLS needs and priorities.

Planning for the local needs of indigenous communities will build upon work being done at the provincial level, including the development of the Aboriginal and First Nations Health Council, the provincial Aboriginal Wellness Strategy, the Aboriginal Diabetes Strategy and the Provincial Aboriginal Leads Network's Annual Action Plan.

The objectives of the Central West Palliative Care Network are aligned with the standards detailed in the Ministry of Health and Long Term Care document: *"Advancing High Quality, High Value Palliative Care in Ontario, Declaration of Partnership and Commitment to Action"* (2011). Members of the Central West Palliative Care Network play active roles on the Hospice Palliative Care Provincial Steering Committee and its sub committees.

Action Plans/Interventions	2014/15	2015/16	2016/17
All health service providers will develop 3 to 5 year Health Equity Plans.	In Progress 50%	25%	Ongoing
Develop business case for a Language Interpretation Model for community sector service providers and hospitals.	In Progress 100%	Ongoing	Ongoing
In collaboration with Reflet Salvéo and partnering LHINs, implement Central West LHIN specific action items from the French Language Services (FLS) Joint Annual Action Plan.	In Progress 100%	Ongoing	Ongoing
Develop FLS capacity in Central West Health Service Providers through an enhanced active offer of services, building on bilingual health human resources as identified in the Yearly Implementation Plans of the four "identified" providers.	In Progress 33%	33%	Ongoing
Engage local Aboriginal and First Nations community in a minimum of three activities/year.	In Progress 33%	33%	Ongoing
Implement the Shared Care Model of Palliative Care (including filling nursing, medical director and other positions as funding becomes available)	In Progress 75%	25%	
Work with Long-Term Care Homes to develop programs to enhance the delivery of high quality palliative care in the long term care environment.	Not Yet Started 50%	25%	25%
Work with acute care hospitals to develop inpatient and outpatient resources that are fully integrated with community-based palliative services.	Not Yet Started 50%	25%	25%

Expected Impacts of Key Action Items
In providing services through a Health Equity lens, we will achieve better access, better value and better quality of care for all residents in the Central West LHIN. **Outcome Metrics:** ▪ Increase compliance with and reporting of Local Indicators for French Language Service requirements; Health Equity Plans; Palliative Care; and Woman/Children's Health among funded Health Service Providers as specified in their Service Accountability Agreements (SAAs). ▪ Monitor the proportion of Francophone and Aboriginal Peoples reporting access to a regular medical doctor. ▪ Establish a baseline and target to reduce the total number of hospital days that are attributed to palliative care. ▪ Increase the number of emergency department visits averted for community-based palliative patients by 5% by 2015/2016.

Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Lack of reliable data on the use of health care services by members of specific communities limits local knowledge of service utilization among diverse populations.	▪ The LHIN will focus on monitoring and tracking available data that captures residents' access to and utilization of services by race, culture, language and gender. ▪ LHIN staff will continue to work with its counterparts at the local and provincial level to determine challenges and opportunities for collecting data that encompasses information about race, culture, language and gender.
Engagement and scope of activities for local Aboriginal organizations are limited by the lack of specific health mandates and limited resources.	▪ Engagement activities will aim to build the capacity of our Aboriginal community organizations. This will strengthen both the LHIN's understanding of health care issues and the organizations' capacity to engage with the LHIN on health planning. ▪ The LHIN will identify key priorities specific to the population needs and scoping projects.
Service and resource pressures driven by population growth may deflect attention away from specific needs of high-risk communities.	▪ All of the LHIN's Core Action Groups will continue to display an understanding of and explore challenges and opportunities to improve access to culturally competent care for marginalized, disadvantaged, and hard-to-reach residents of the Central West LHIN.
Differing priorities between health service partners may delay the achievements of action items related to Health Equity, French Language, and Palliative Care.	▪ The LHIN will continue to ensure funded agencies develop and Health Equity and French Language Services plans. ▪ When necessary, support will be provided through the Diversity and Health Equity and French Language Services Core Action Groups and the Central West Palliative Care Network.

Key Enablers

Building on relationships established with the LHIN's Core Action Groups, local Aboriginal communities and the Palliative Care Network, the LHIN and its Board of Directors will continue to provide support and improve services for these priority populations. Strong leadership will enhance cooperation and engagement amongst the diverse partners and active participation and inclusion amongst the LHIN in locally hosted activities will allow us to learn from our peers, adopt best practices and deliver culturally-sensitive, compassionate services to residents.

SECTION 3 | Financial Plan: Operations & Staffing

3.1 Three-Year LHIN Operations Spending Plan

LHIN Operations Spending Plan						
LHIN Operations Sub-Category ($)	2012/13 Allocation	2012/13 Actuals	2013/14 Planned Expenses	2014/15 Planned Expenses	2015/16 Planned Expenses	2016/17 Planned Expenses
Salaries and Wages	2,188,004	2,161,339	2,304,489	2,324,079	2,351,665	2,375,371
EMPLOYEE BENEFITS						
HOOPP	217,615	218,914	230,449	232,408	235,167	237,537
Other Benefits	240,356	312,050	188,495	255,649	258,683	261,291
Total Employee Benefits	**457,971**	**530,964**	**483,944**	**488,057**	**493,580**	**498,828**
TRANSPORTATION AND COMMUNICATION						
Staff Travel	30,000	16,345	30,000	30,000	25,000	25,000
Governance Travel	20,000	14,666	20,000	20,000	20,000	20,000
Communications	65,000	61,937	77,000	75,000	70,000	70,000
Other	34,584	34,584	78,424	-	-	-
Total Transportation and Communication	**149,584**	**127,532**	**205,424**	**125,000**	**115,000**	**115,000**
SERVICES						
Accommodation	241,380	240,117	233,716	240,000	240,000	240,000
Advertising	20,000	17,056	14,942	15,000	15,000	15,000
Banking	100	75	147	100	100	100
Consulting Fees	297,628	173,352	182,695	182,992	164,613	145,929
Equipment Rentals	8,500	8,933	6,871	9,000	9,000	9,000
Insurance	7,000	31,630	7,000	7,000	7,000	7,000
LSSO Shared Costs	342,000	411,520	342,000	342,000	342,000	342,000
LHIN Collaborative	47,500	47,500	47,500	47,500	47,500	47,500
Other Meeting Expenses	25,000	14,969	25,000	20,000	20,000	20,000
Board Chair's Per Diem Expenses	72,800	69,125	72,800	72,800	72,800	72,800
Other Board Members' Per Diem Expenses	84,500	76,060	92,300	92,300	92,300	92,300
Other Governance Costs	24,000	30,314	30,000	30,000	30,000	30,000
Printing and Translation	45,000	45,560	57,000	50,000	50,000	50,000
Staff Development	46,000	29,373	46,000	46,000	46,000	40,000
Total Services	**1,261,408**	**1,195,574**	**1,157,971**	**1,154,692**	**1,136,313**	**1,111,629**
IT Equipment	20,000	32,863	20,000	20,000	20,000	18,000
Office Supplies & Purchased Equipment	49,995	44,754	50,000	50,000	45,000	45,000
Total Supplies and Equipment	**69,995**	**77,617**	**70,000**	**70,000**	**65,000**	**63,000**
Capital Expenditures	25,000	25,750	25,000	20,000	20,000	18,000
LHIN Operations: Total Planned Expense	**4,151,962**	**4,118,776**	**4,181,828**	**4,181,828**	**4,181,828**	**4,181,828**
Annual Funding Target	4,181,828	4,151,962	4,181,828	4,181,828	4,181,828	4,181,828
Surplus	29,866	33,186	-	-	-	-
INITIATIVES SPECIFIC FUNDING						
French Language Services	75,606	65,000	106,000	106,000	106,000	106,000
Annual Funding Target	106,000	75,606	106,000	106,000	106,000	106,000
French Language Services Surplus	30,394	10,603	-	-	-	-
Diabetes Regional Coordination Centre	-	30,127	529,223	856,301	856,301	856,301
Annual Funding Target	-	142,717	856,301	856,301	856,301	856,301
Diabetes Regional Coordination Centre Surplus	-	112,590	327,078	-	-	-
Aboriginal Community Engagement	2,500	-	7,500	7,500	7,500	7,500
Annual Funding Target	7,500	2,500	7,500	7,500	7,500	7,500
Aboriginal Community Engagement Surplus	5,000	2,500	-	-	-	-

3.2 Three-Year LHIN Staffing Plan

Central West LHIN Staffing						
Position Title	2012/13 Allocation FTEs	2012/13 Actuals FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs	2016/17 Forecast FTEs
CEO	1	1	1	1	1	1
Senior Director, Health System Performance	1	1	1	1	1	1
Senior Director, Health System Integration	1	1	1	1	1	1
Executive Assistant	2	2	2	2	2	2
Administrative Assistant, Health System Performance	1	1	1	1	1	1
Administrative Assistant, Health System Integration	1	1	1	1	1	1
Board and CEO Liaison	1	1	1	1	1	1
Director, Health System Integration	4	4	4	4	4	4
Director, Funding and Allocation	2	2	2	2	2	2
Director, Performance & Accountability	1	1	1	1	1	1
Director, Quality	1	1	1	1	1	1
Director, Communication and Community Engagement	1	1	1	1	1	1
Director, ER/ALC/Decision Support	1	1	1	1	1	1
Specialist, Performance & Quality	1	1	1	1	1	1
Specialist, Performance & Integration	1	1	1	1	1	1
Specialist, Decision Support	1	1	1	1	1	1
Specialist, Performance	1	1	1	1	1	1
LHIN Operations Manager	1	1	1	1	1	1
Director, Health System Integration (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
Administrative Assistant (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
Health Integration Specialists (Diabetes Regional Coordination Centre) *	2	2	2	2	2	2
Specialist, Decision Support (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
French Language Services Coordinator	1	1	1	1	1	1
Total FTEs	29	29	29	29	29	29

SECTION 4 | Communications & Community Engagement

The communications strategy outlined below will guide the communications and community engagement activities of the Central West LHIN, its Board of Directors, Staff, and local Health Service Providers in support of the strategic directions outlined in the IHSP 3 and the ABP 2014/15.

Communication Objectives

- Foster an understanding of the need for continued health system transformation.
- Build ongoing support for an integrated sustainable health care system that ensures better health, better care and better value.
- Encourage both organizations and individuals to actively engage in the planning and development of the local health system, and to share in the benefits / success of health system transformation.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.
- Provide information on performance and progress regarding implementation; document and disseminate successes.
- Raise awareness of the Central West LHIN's role, its unique characteristics, value proposition and importance within the health care system.
- Educate and build awareness among HSPs regarding shared accountability for health system transformation and the alignment of their respective /initiatives with IHSP 3.
- Continue to build strong, trusted relationships with HSP communications teams across the Central West LHIN, working together to optimize communication resources and coordinated services.
- Ensure stakeholders understand their role to identify new opportunities for the appropriate, coordinated, effective and efficient integration of services.
- Continue to build strong relationships with elected officials, community leaders and leaders of health care organizations, with the goal of providing community satisfaction in regard local health care services.
- Demonstrate the value of the Central West LHIN to local residents.
- Provide accurate and timely information to all audiences regarding the progress of LHIN activities and be transparent and accountable with respect to timelines, outcomes and opportunities for participation/feedback.
- Sustain a reputation among media outlets across the LHIN that the Central West LHIN operates in an open and transparent fashion, respectful of their needs for timely and accurate response.

Context

Ontario's Action Plan for Health Care places LHINs at the centre of health system transformation and, as a result, the health care system has evolved to the point where LHINs are being recognized as local system managers that play a central leadership role in driving health system transformation. LHINs have a critical role to play in key provincial initiatives recently introduced such as HSFR, Health Links, Ontario's Seniors Strategy and the expansion of QIPs into the primary, community and Long-Term Care sectors. Consequently, the Central West LHIN's IHSP 3 and accompanying ABP 2014/2015 strategically align with the Ministry's direction and priorities.

Stakeholders

Depending on the situation, primary and/or secondary stakeholders (audiences) will include:

- HSPs from across the Central West LHIN and, as is deemed appropriate, surrounding LHINs:
  - Leadership, Front Line Staff and Boards of Directors as required
  - Physicians and clinicians
  - Patients/Clients/Consumers/Residents
  - Consumer/Patient Support Groups
  - Healthcare Associations (OHA, ONA, OMA, etc.)
- Government
  - Municipal
  - Regional
  - Provincial (including Ministry of Health and Long-Term Care, other ministries as appropriate)
  - Federal
- General Public
  - Residents
  - Community Organizations
- Media
- LHINs

Strategic Approach

- Position the LHIN as a valued partner in the transformation of Ontario's health system.
- Position the LHIN as the leader of localized health system transformation.
- Position the work of the LHIN and local HSPs as a comprehensive and meaningful redesign of the way by which local health care needs are being heard, understood, addressed and met.
- Position the work of the LHIN as a model for "Healthy Change" that successfully breaks down barriers, encourages collaborative work, shares knowledge and fosters partnerships among local, regional and provincial agencies.
- Develop and leverage opportunities to build the reputation and establish credibility of the Central West LHIN.
- Ensure that effective Community Engagement and input takes place at the most appropriate juncture(s) of a program or operational planning process that requires careful and comprehensive public consultation.

Tactics

- **Media** - In an effort to reach a variety of audiences, the Central West LHIN will seek to maintain and build upon existing relationships, while exploring new channels where deemed appropriate.
  - **Print**: When and as required, the Central West LHIN will issue appropriate and timely news releases, opinion editorials and matt stories to educate and inform communities regarding the current happenings and goings on the local health care system.
  - **Broadcast**: The LHIN will look at opportunities to formalize its presence on television and radio platforms.
  - **Social / Online**: The Central West LHIN will look to formalize its presence with online/social media by devoting time and resources to establishing a formal social media policy, effectively managing new and existing content and committing to the development and use of interactive video content.

- **Publications**: While the LHIN will continue to design and publish regular, targeted newsletters to a variety of stakeholders, their number, frequency and method of delivery will be reviewed to ensure they are meeting the needs of the intended audiences.

- **Stakeholder Events -** Whenever possible, the Central West LHIN Board and/or Staff will participate in stakeholder engagement opportunities including but not limited to town halls, partner events, sponsored events, ground breaking ceremonies, facility openings, funding announcements, program/initiative announcements, media opportunities etc.
- **Speakers Bureau, Industry and Public Events/Conferences** – When and where deemed appropriate, the Central West LHIN Board of Directors and Staff will continue to participate in key public health fairs and conferences at which they will have the opportunity to showcase LHIN activities, programs, achievements and successes.
- **Regional and Municipal Councils, and MPP Contact** - The LHIN will continue to meet regularly and communicate with regional, municipal and civic councils and MPPs across the area, to update them on achievements at the LHIN and to provide context on how work being done might impact their specific constituencies.
- **Brand Leveraging** – As local residents experience their health care system through their Health Service Providers, the Central West LHIN will seek to further leverage the brands and communication channels of key partners in order to more effectively deliver LHIN messages and information to local residents.

Key Messages

While different situations and issues will require specific messaging appropriate to the circumstances in which they arise, overall key messages should be adopted throughout the Central West LHIN's Communications & Community Engagement Plan. They include:

Transformation Messages

Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on the medical evidence, we will provide Ontarians with better care and better value for tax dollars.

Through these changes, we expect to see:

- Reduced wait times and faster access to family doctors.
- Fewer unnecessary visits to the emergency room and re-admissions to hospital.
- Patients receiving care at home or in the community instead of in a hospital.

How are we transforming the health care system?

- Partnering with the sector and enabling Health Service Providers and residents to play an active role in how the system will change.
- Strengthening community agencies to support providers and encourage integration around the patient's needs.
- Health care funding will be determined based on the best evidence and will follow the patient.

What can we expect from these changes to the healthcare system?

- A system built for patients by the Health Service Providers and leaders closest to them.
- A health care system that integrates providers around patients to deliver better outcomes.

Local LHIN Messages

The Central West LHIN has a strategic and operational plan to ensure local residents have access to high quality, localized care, and a sustainable health care system for years to come.

- The Central West LHIN is making the system work more like a system. By organizing the system differently and focusing on the medical evidence, the LHIN provides local residents with better care, better health and better value for their tax dollars.
- The Central West LHIN recognizes that the system looks different in the communities across the area. The LHIN builds on these differences because they reflect the diverse needs of local communities.

The Central West LHIN and local HSPs continue to bring about significant and positive change to ensure better patient outcomes.

- The Central West LHIN maintains Accountability and Performance agreements with the Ministry and with local HSP's. These agreements set out in detail, targets to be achieved within agreed time frames to ensure that the quality of care for residents in the LHIN is maintained to the highest-possible standards.
- Bringing together local HSPs around the same table has been a critical step in creating a common vision of achieving a system that is built around patients and their communities, not providers themselves.

The Central West LHIN is committed to building a more seamless and coordinated approach to patient care.

- Silos, fragmentation, duplication and gaps in service delivery can have a dramatic impact on patient outcomes and people's experience with the health system. This is why the Central West LHIN has made it a strategic priority to streamline transitions and navigation across and throughout the health care system.

The Central West LHIN brings together health care partners, such as hospitals and community-based agencies, to develop innovative, collaborative solutions, and is working with local partners to provide a more coordinated, value-driven health care system that provides improved access to high-quality, localized care, improved wellness and an improved overall patient experience.

- The Health Links initiative is making a difference with its collaborative approach to promotion, awareness and education, in addition to the manner by which residents receive their care. Through increased funding to community services, patients are receiving care at home or in their community instead of a hospital.

The Central West LHIN is reducing waste in the system by identifying opportunities for local service providers to work better together to reduce duplication and delays, and avoid unnecessary costs.

- Prior to the LHIN, many health care agencies and organizations worked separately in silos that created gaps in which patients were often left frustrated and confused about how and where to get the best care. The Central West LHIN has improved coordination among providers, with an emphasis on transition points, so that patients are transferred more smoothly and effectively from one sector of care to another.
- Through Performance Agreements with the LHIN health service providers in this region are being held accountable for the ways in which they provide quality driven, evidence based health care.
- The Central West LHIN is a leading organization by which Primary Health Care will be strengthened, through the establishment of Health Links and the bolstering of Community-based health care services.

Action Plan

Tactic	Timeline(s)	Responsibility	Context
News Releases	As required, to highlight/promote Central West LHIN activities/events.	Communications	In conjunction with program areas as required.
Success Stories	Support timely/effective impact of good news on appropriate audience(s).	Program Leads	Program areas will "feed" material to Communications.
LHINfo Minute	Monthly newsletter to a general audience.	Communications	Info and fact-checking by program area.
LHINfocus	Bi-annual publication to recap and check in on progress made throughout the fiscal year.	Communications	Info and fact-checking by program area.
MPP / Municipal Briefing Notes (Updates)	Sent to MPP's and Municipal Leaders monthly.	Communications	Fed from monthly CEO update to the Board.
MPP Meetings	Quarterly	Central West LHIN Board Chair and CEO	With support from communications.
G2G Sessions	Quarterly	Communications	Support provided to Board of Directors.
Regional, Municipal, Civic Council Meetings	Meet/present to these bodies regularly, contingent on schedule availability.	Central West LHIN Board Chair and CEO	With support from communications.
Conferences	As appropriate	Relevant Program Area aligned to topic or theme of event	
Speakers bureau (opportunities)	As appropriate	CEO, Senior Directors to identify opportunities	Speaking notes supplied by Communications as required.
Board Materials	Ahead of and following monthly Board meetings.	Board and CEOLiaison	
Media Outreach – Print, Broadcast, Online	Ongoing	Communications	Participation by program area(s) for background and/or education
Website – Content Management and Updating	Ongoing	Communications	Preparation and postings of materials to be handled by Program area, with vetting by Communications to ensure messaging content and tone.

FIPPA requests	As required. Timing to align with Legislation requirements	Communications to manage, with timely input from program areas.	
MOHLTC Requests for information/analysis	As required. Usually on immediate turnaround.	Communications to coordinate with input from program areas.	
French Language Services coordination	As required to further Central West LHIN and/or Reflet Salvéo with communications plans	FLS Coordinator, with assistance from Communications	

Evaluation

Identifying and tracking communication success factors enables the Central West LHIN to more effectively identify whether communication activities have been successful. Using the following measures, a formal and comprehensive evaluation of the LHIN's communications efforts will be carried out in-house.

- Positive editorial coverage/limited negative editorial coverage: this information will be collected and evaluated within a context of transparent disclosure.
- Website traffic: using analytics, pages and specific postings are tracked.
- Social media metrics:
  - Growth of social reach e.g. number of Twitter followers/mentions; number of YouTube views/subscribers
  - Appreciation of social media content e.g. Twitter / YouTube comments, Twitter favourites.
  - Increased visits on the Central West LHIN website as a direct result of social media presence.
- Evaluate LHIN community engagement by monitoring and measuring tone and volume of traditional media, online/social media (e.g., websites, Twitter) and LHIN communication vehicles (blast emails, bulletins).
- Visible senior leadership engagement and support for the communications & community engagement activities associated with the IHSP 3 strategic directions and ABP 2014/2015 initiatives.
- Active participation of LHIN Board Members in support of communications & community engagement.
- A clear understanding, by key stakeholders, of the LHIN"s strategic and operational plans, and how they play a role towards their successful realization.
- The appropriate, early and frequent engagement of HSPs to demonstrate how their ongoing participation impacts successful realization of desired outcomes.
- The level to and frequency by which residents are engaged by and with the Central West LHIN using a variety of instruments, including traditional media, online/social media and LHIN communication vehicles.
- The use of feedback mechanisms and ongoing assessment tools to monitor the effectiveness of communication vehicles and messages.

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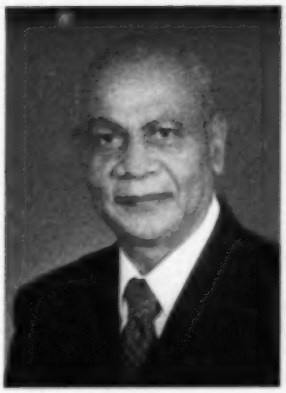
Lorraine Gandolfo
Director

Suzan Hall
Director



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C'est pour vous
C'est pour votre santé!

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